TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
AHMED KHALIFA MD

MFDR Tracking Number
M4-17-3813-01

MFDR Date Received
August 22, 2017

Respondent Name
MANUFACTURERS ALLIANCE INSURANCE

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There has been o payment issued on this claim and therefore, the total amount due is noted on the [sic] on the original HCFA claim form as attached to this Request for Reconsideration."

Amount in Dispute: $332.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the carrier would show that the provider is not entitled to any reimbursement as set out on the carrier's EOR dated October 19, 2016."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 12, 2016	99367	$332.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for Workers' Compensation Specific Services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Code 99367 (Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician) rendered on September 12, 2016. The insurance carrier denied the disputed service with denial reason code "P12 – Workers' compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.204 states in pertinent part, "(e) Case Management Responsibilities by the Treating Doctor is as follows... (4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361.... (B) CPT Code 99362... (C) CPT Code 99371... (D) CPT Code 99372... (E) CPT Code 99373."

   Review of the submitted documentation titled "*Case Management Meeting"* dated September 12, 2016, documents that the service rendered is a case management service. Per 28 Texas Administrative Code the requestor was required to bill using Division specific CPT Codes, 99361, 99362, 99371, 99372 or 99373 for the case management service.

2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the disputed services. As a result, $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 10, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.